HEALING THE HEALTH CARE SYSTEM:

ASIAN AMERICAN VOICES FOR HEALTH CARE REFORM

BY **PROJECT CHARGE** (COALITION FOR HEALTH ACCESS TO REACH GREATER EQUITY)
APRIL 2010

Project CHARGE Partners

Project CHARGE (Coalition for Health Access to Reach Greater Equity) is a health collaborative of 15 partner organizations that have come together to address health access for Asian Americans in NYC. The collaborative focuses on increasing access to public and private, employer-based health insurance. It advocates expanded services for people enrolling in public plans, including culturally competent and language-accessible enrollment initiatives and expansion of critical "enabling services," such as language assistance, transportation, outreach, health education, and case management.

Project CHARGE is part of Health Through Action (HTA), a $16.5 million, five-year partnership between the W.K. Kellogg Foundation and the Asian and Pacific Islander American Health Forum (APIAHF). This is the first such cooperative effort to improve health and reduce health care disparities for the Asian American, Native Hawaiian, and Pacific Islander populations. The Coalition for Asian American Children and Families (CACF) is the coordinating agency of Project CHARGE.

Project CHARGE partners are:

- Asian Americans for Equality – a community development organization
- Asian & Pacific Islander Coalition on HIV/AIDS – a pan-Asian HIV/AIDS clinic & organization
- Center for the Study of Asian American Health at New York University – a research center
- Child Center of New York, Asian Outreach Program – a federally qualified health clinic
- Chinese-American Planning Council – a social service organization
- Coalition for Asian American Children & Families – a pan-Asian children's advocacy organization
- Family Health Project – a public health advocacy and prevention education organization
- Henry Street Settlement – a provider of many health, behavioral, and support services
- Kalusugan Coalition – a Filipino health coalition
- Korean Community Services of Metropolitan New York – a social service organization
- MAAWS for Global Welfare – a Bangladeshi community based organization
- New York Asian Women's Center – a pan-Asian domestic violence organization
- NYU South Asian Health Initiative – an outreach and education initiative
- John Chin, Ph.D., Hunter College – the project evaluator

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DISCLAIMER

Opinions and recommendations expressed in this report are those of Project CHARGE and do not necessarily represent the views of individuals, organizations, and funders.

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EXECUTIVE SUMMARY

During this time of growing numbers of uninsured and skyrocketing costs of health care, the passage of the historic health care reform legislation, the *Patient Protection and Affordable Care Act (H.R. 3590)* as amended by *Health Care and Education Reconciliation Act of 2010 (H.R. 4872)*, will dramatically improve the state of health care for the United States. It promises to expand access to approximately 32 million Americans.

Efforts to pass health care reform rose up from a growing discontent from health consumers and providers alike about the challenges they face in getting and providing health care. Consumers too often have been shut out, confused, and frustrated by our complex and fragmented health care system. Throughout the country, many have come together to share their stories, concerns, opinions, and have shaped the health care reform debate.

This report presents key findings from a series of community health care discussions of Asian American community members in New York City conducted by Project CHARGE. **Project CHARGE** (Coalition for Health Access to Reach Greater Equity) is a New York City based collaborative of 15 organizations devoted to improving healthcare

access for Asian Americans through capacity building and health policy advocacy. The top 3 concerns expressed by the 128 participants included:

1. **Asian Americans are worried about the rising costs of care.**
2. **Language barriers remain for Asian Americans even with language access laws.**
3. **Few health education and outreach efforts are targeting Asian Americans.**

Based on the findings from the community health care discussions, Project CHARGE analyzed how particular provisions from the *Patient Protection and Affordable Care Act (H.R. 3590)* and the *Health Care and Education Reconciliation Act of 2010 (H.R. 4872)* impact the Asian American community in 8 key areas. Starting in 2014, most U.S. citizens and legal residents will be required to have health insurance. While many improvements and benefits will be garnered from the passage of the health care reform legislation, there is still a long road ahead to ensure a truly inclusive and accessible health care system in which no one is left out.

1. Affordability


Individual Credits & Subsidies - Affordability credits for premiums and cost-sharing will be available for U.S. citizens and legal immigrants who have incomes up to 400% of the federal poverty level.


Small Business Tax Credits - Affordability credits will be available immediately to help small businesses afford health coverage (less than 25 full-time employees and/or average wages less than $50,000/year). This includes a credit up to 35% of the employer's contribution to provide health insurance for employees. For small nonprofit organizations, the credit is 25% of employer's contributions.


Self-Employed Business Owners - Affordability credits will be available on a sliding scale basis for premiums and there will be caps on out-of-pocket costs for self-employed business owners.


Out-of-Pocket Prescription Costs- $250 rebates will be provided for Medicare Part D enrollees who enter the "donut hole" to help pay for prescription drugs. In subsequent years, additional discounts will be provided for seniors. The coverage gap will continually narrow until it disappears by 2020.

2. Expansion of Coverage and Care


Dependent Coverage - Starting in 2010, unmarried adult children can remain on their parents' insurance plan up to age 26.


Preventive Care - Under new plans, consumers will not have to pay out-of-pocket costs for wellness and preventive care such as mammograms, immunizations, and screenings for cancer, cardiovascular disease, and diabetes.

3. Immigrant Inclusion


5-Year Waiting Period for Legal Immigrants - Legal immigrants who would otherwise qualify for these services are unfairly denied access to public programs for five years even though they pay taxes like everyone else. With the mandates included in the health care reform legislation, these same individuals will now be required to purchase insurance unless they can prove financial hardship. Progressive states, like New York who do not have a 5-year bar, will continue to shoulder the costs of providing these programs with state only dollars.


Undocumented Immigrants & the Exchange - Undocumented immigrants are prohibited from using their *own* money to purchase insurance through the Exchange at full cost.


Additional Verification - To prevent undocumented immigrants from accessing the Exchange, the health care reform legislation includes additional, burdensome proof of citizenship or lawful presence requirements. States already implement a verification system to determine eligibility for public programs and this would create more administrative and financial burdens. This places an extra burden on everyone, citizens and legal immigrants alike.

4. Language Access and Cultural Competency


Language Requirements - All insurance summaries, claims, and notices to enrollees must be provided in culturally competent and linguistically accessible (CCLA) manner.

 Standards & State Grants for Language Access - Despite the CCLA requirements, the health care reform legislation does not include standards in which this will be done across health plans. *A critical improvement to this current provision will be to establish Culturally and Linguistically Appropriate Services (CLAS) standards for insurers in the Exchange*. Additionally, federal funds should be allocated to States to establish a grant program to develop an infrastructure for language services.

 Matching Rate - An enhanced matching rate for the reimbursement of language services was *not included* in the health care reform legislation. *A critical improvement to the current legislation will be the inclusion of a provision that increases the federal matching rate for language services*. For instance, a 75% matching rate is available for providers that offer language services for children in Medicaid and the Children's Health Insurance Program. This should be extended to Medicaid providers that offer language services to their adult patients.

 Cultural Competency - There are several provisions that focus specifically on culturally competent care in the areas of pediatric health care workforce expansion, primary care training and enhancement, education and training in pain care, and mental and behavioral health education and training grants.

5. Consumer Protections, Assistance, and Outreach

 Consumer Protections - There are several provisions that protect health consumers from discriminatory insurance practices. These include prohibiting denials of coverage based on a pre-existing condition for adults and children. It also guarantees access to coverage regardless of age, gender, or health status. Additionally, the legislation eliminates lifetime and annual coverage limits.

 Accountability - Health insurance companies will be held accountable for how premium dollars are spent. They will now be required to spend 80-85% of their premium dollars on patient care and not for profits, advertising, and other overhead costs. Patient care is any service performed by a health professional or non-health professional for the benefit of the patient. These can include treatments, counseling, patient education, and administration of medication. If insurers fail to do this, they will be required to provide refunds to their consumers.

 Consumer Assistance Resources - All insurers in the Exchanges will be required to present health information in a clear, user-friendly format that allows consumers to understand and compare available benefits and plans. This will be done via call centers, websites, and contracted navigators to conduct outreach and enrollment assistance. Insurers will be subject to marketing requirements and uniform standards for information dissemination. Consumers will have a variety of ways to apply for subsidy programs through a single form that can be filled out online, in person, mail, or by phone. *However, it is uncertain what mechanisms will be in place for Limited English Proficient individuals to use these resources.*

6. Disparities

 Data Collection - Within two years, any federally conducted or funded research, public health programs, or activity must collect and report data on race, ethnicity, sex, primary language, and disability status. Additionally, efforts to oversample populations that have traditionally had low participation in research studies will be implemented as well as ongoing monitoring to determine trends in health disparities.

 Workforce Development - Several provisions were included in the health care reform legislation that will improve workforce training and development, provide scholarships and loan repayment programs, training in cultural competency, as well as funding for community health workers.

7. Safety Net

 Community Health Center - Funds will be increased by $11 billion over 5 years towards

community health centers to expand and build their capacity to serve thousands of newly insured patients.

Safety-Net Hospitals and Clinics - While the health care reform legislation will expand coverage to nearly 32 million individuals, there will be many that remain uninsured. *The funding of these safety net providers must continue to be protected as they will continue to offer affordable care for many low-income individuals and families that do not qualify for affordability credits or get coverage through their employers.*

8. State Commitment

Medicaid - Expands Medicaid to 133% of the federal poverty level and extends Medicaid eligibility to citizens of the Compact of Free Association States. All newly eligible adults (non-elderly, non-pregnant adults) will be guaranteed a benchmark benefit package that at least provides the essential health benefits.

State Relief and Support - To finance coverage for newly eligible Medicaid recipients, states will receive 100% of federal medical assistance percentage (FMAP) funding in 2014 and draws down to 90% by 2020. For states that already provide expansion of eligibility to adults with incomes up to 100% (like New York), they will receive a phased-in increase in funding for FMAP so that by 2019 all states will receive the same federal financing for Medicaid. *Given tough economic times, more generous states face difficult decisions about what it can afford to provide its residents moving forward.*

As the next phase of health care reform turns to states to develop their implementation plans, finding ways to involve community members is crucial to shaping sound processes for education, outreach, coordination, execution, and evaluation of this new health care system. Policymakers must prioritize engaging all communities, including Limited English Proficient, newly arrived immigrants, and low-income communities. The costs of not doing so are enormous, and all of us will lose out in building a healthy, productive country together.

INTRODUCTION

During this time of growing numbers of uninsured and skyrocketing costs of health care, the passage of the historic health care reform legislation, the *Patient Protection and Affordable Care Act (H.R. 3590)* and the *Health Care and Education Reconciliation Act of 2010 (H.R. 4872)*, will dramatically improve the state of health care for the United States. Efforts to pass health care reform rose up from a growing discontent from health consumers and providers alike about the challenges they face in getting and providing health care. Consumers too often have been shut out, confused, and frustrated by our complex and fragmented health care system. Throughout the country, many have come together to share their stories, concerns, opinions, and have shaped the health care reform debate.

This report presents key findings from a series of community health care discussions of Asian American community members in New York City. The top 3 concerns expressed by the 128 participants included costs, language barriers, and lack of education and outreach efforts targeting the community.

Based on these findings, the report also provides a summary of how particular provisions from the *Patient Protection and Affordable Care Act (H.R. 3590)* and the *Health Care and Education Reconciliation Act of 2010 (H.R. 4872)* impact the Asian American community in 8 key areas: affordability, expansions in coverage and care, immigrant inclusion, language access, consumer protections/assistance/outreach, disparities, safety net, and state commitment.

The community health care discussions were developed, conducted, and analyzed by Project CHARGE (Coalition for Health Access to Reach Greater Equity). Project CHARGE is a New York City based collaborative of 15 organizations devoted to improving healthcare access for Asian Americans through capacity building and health policy advocacy. In 2008, Project CHARGE became 1 of 12 grantees in 10 states funded by Health Through Action (HTA), a national initiative organized by the Asian and Pacific Islander American Health Forum (APIAHF) with funding from the W.K. Kellogg Foundation to support local community-based projects working to reduce health disparities among Asian Americans, Native Hawaiians, and Pacific Islanders.

While many improvements and benefits will be garnered from the passage of the health care reform legislation, there is still a long road ahead to ensure a truly inclusive and accessible health care system in which no one is left out.

BACKGROUND

Asian Americans and Health Coverage

Today **over 47 million people lack health insurance in America** and although communities of color account for about one third of U.S. population, they account for more than half of the uninsured (Palmer, 2009).

Currently, there are **2.3 million uninsured Asian Americans nationally**. The highest rates nationally are among Koreans (31%), Vietnamese (21%), and other South Asians (20%) (Henry J. Kaiser Family Foundation and the Asian & Pacific Islander American Health Forum, 2008).

Table 1: Asian New Yorker Statistics at a Glance

Population	
Alone or In-Combination Population in 2007	1,046,082
Population in Queens (as a Percentage of NYC Pop.)	516,570 (49%)
Population in Brooklyn	244,495 (23%)
Population in Manhattan	191,548 (18%)
Population in the Bronx	55,466 (5%)
Population in Staten Island	38,003 (4%)
Immigration and Citizenship	
Foreign-Born Percentage of Total Population	72%
Citizenship Percentage of Foreign-Born	53%
Educational Attainment (Adults 25 and Older)	
Percentage of Adults Without a High School Diploma	24%
Percentage of Adults With Some College Education	54%
Limited English Proficiency (Speaks English "Well," "Not Well" or "Not at All"	
Percentage of Total Population	48%
Income	
Median Household Income	$50,847
Median Family Income	$52,661
Per Capita Income	$24,461
Poverty	
Percentage of Total Population Living in Poverty	17%
Percentage of Children Living in Poverty	21%
Percentage of Elderly Living in Poverty	26%

Source: Asian American Federation, 2009

In New York City, 1 in 8 Asian Americans has been uninsured in the past year. The overwhelming majority of uninsured Asian Americans in New York City are **foreign born (83% or 65,000)** (New York City Department of Health and Mental Hygiene, 2008).

While 65% of Asian Americans receive health care through their employers, the remaining 35% are **self-employed, working in small businesses or in cash-based industries that are less likely to offer health benefits** (Asian & Pacific Islander American Health Forum, 2009).

Healthcare access problems are exacerbated in Asian American communities by immigration status, language barriers, cultural stigmas regarding public benefits, and low utilization of primary and preventive care.

Asian Americans in New York City

According to the Asian American Federation Census Information Center, there are over one million Asian Americans currently living in New York City. New York City's Asian population has grown tremendously in both size and diversity since 2000.

According to the most recent American Community Survey (ACS) data, 72% of Asian Americans in

Table 2: Ethnic Asian Population in New York City

Asian Ethnic Group	Population in New York City	% Growth in Population from 2000 to 2009
Bangladeshi	27,804	-2%
Chinese	466,146	17%
Filipino	75,352	21%
Indian	247,292	20%
Japanese	28,711	9%
Korean	94,711	5%
Pakistani	26,665	-22%

Source: Asian American Federation, 2009

New York State lived in New York City. Asians now represent over 12% of New York City's residents, a 2% increase since 2000. According to the Census Bureau Population Estimates, the Asian population in New York City grew by almost 17% from 896,764 in 2000 to 1,046,082 in 2007 (Asian American Federation, 2009).

The four largest Asian groups in New York City are Chinese (45% of all Asians), Indians (24%), Koreans (10%), and Filipinos (7%). Bangladeshi, Japanese, and Pakistani are each 3% of the Asian population, and Vietnamese are 2%. Table 2 shows the population of each of these ethnic groups and the percent change from 2000 (Asian American Federation, 2009).

This demographic information encourages a reinvestigation of the "model minority" myth for Asian New Yorkers. The term "model minority" was coined in the mid-1960s by William Petersen to describe Asian Americans as ethnic minorities who, despite marginalization, have achieved success in the United States. Unfortunately, this stereotype has lead to assumptions that Asian Americans do not face genuine struggles when it comes to their education, work, health, or other myriad of issues. However, looking at immigration and citizenship status, education attainment of adults 25 and older, limited English proficiency, median income and levels of poverty, it becomes clear that the Asian American community in New York City is complex and do in fact experience significant challenges to their health and well-being.

Why Health Care Reform is Needed Now

Comprehensive and affordable health insurance coverage provides individuals a valuable facilitator to gain access to preventive health care services, such as early detection, treatment, and better disease management. However, even those with coverage do not have a sense of security in our current health care system due to unfair health insurance industry practices. Premiums for residents in New York State have risen 97% since 2000 (Center for Financing, 2000 and 2006). Close to 60% of all bankruptcies in the U.S. is a result of medical debt (Himmelstein et al, 2009). The costs of uninsurance or underinsurance to individuals and to society at large are enormous, resulting in poorer quality of life, missed work, bad debt, delay in care due to fear of costs, inefficient care, and diminished benefits of having a healthy, productive population.

VOICES OF ASIAN AMERICANS

While there have been efforts throughout the country to come together to share stories, concerns, and opinions about health reform, Asian American communities were often not included in this larger debate. With a desire to understand the unique challenges facing Asian Americans, to hear about their particular concerns

about health reform, and to provide a space where they could offer recommendations, Project CHARGE members hosted a series of community health care discussions in the summer of 2009.

Project CHARGE members worked together to develop a community discussion guide, translate survey questions, consent forms and handouts, as well as recruited participants. Each partner also attended a 2-hour facilitator training and was involved in the analysis and interpretation of the community discussion results.

To obtain feedback from the Asian American community in New York City, Project CHARGE conducted 15 community discussions and 11 one-on-one interviews with a total of 128 participants. 128 surveys were also administered to each participant for demographic information. Many of the community discussions and interviews were also conducted in the native languages of the participants. Participants represented 9 Asian ethnic groups, had an average age of 43 years, 83% were foreign-born, 42% were employed, 42% lived in the United States for 11 years or more, 21% were uninsured, and 87% had visited a doctor in the last year. (See Appendix A: *Participant Demographics*).

The top three concerns expressed by participants include:

1. Asian Americans are worried about the rising costs of care.

2. Language barriers remain for Asian Americans even with language access laws.

3. Few health education and outreach efforts are targeting Asian Americans.

Asian Americans are worried about the rising costs of care

Like most Americans, Asian Americans feel the pain of our broken health care system and are struggling to keep up with out of control medical costs. 1 out of 2 Asian American New Yorkers indicated health cost as a primary concern in our survey. Concerns with the costs of care were heard among nearly all participants regardless if they were insured or uninsured.

"One day I was feeling extremely ill, but was afraid to call 911 because I heard that it would cost several hundred dollars to call for ambulance services. I'd rather be in pain than be stuck with a large bill I can't pay."

"There are occasions when I am very sick but I won't go to the doctor because it costs money. When I do have insurance, there aren't too many problems. My co-pay is $20, which I think is not bad. But if you're sick and need tests or special procedures, it costs $200 or more, which is a lot of money. If I don't have insurance, then just seeing the doctor is a few hundred dollars. It's terrible, but if my health is bad, I worry about the cost first. The high costs of medical care make(s) me care more about whether or not I can afford the service than about my health and well-being."

"I own my own company and I provide insurance. But the cost per family is close to $2000 per month, which is hardly affordable for those in small businesses. For regular check-ups and follow-ups, the cost is (a) $20 co-pay and that works well for us. But under this coverage, we don't receive referrals. If we have an urgent medical condition that requires a specialist, we are unable to find one with ease. We pay a lot of money and jump through hoops for such limited coverage."

Language Barriers Remain Even with Language Access Laws

The New York State Department of Health (NYSDOH) enacted regulations strengthening patient's rights to language assistance services in all hospitals. Additionally, Mayor Michael Bloomberg

in December 2003 signed into law Intro. 38A, *The Equal Access to Human Services Act, which became Local Law 73 of 2003*. The law sets out to improve access to the City's Medicaid, Food Stamp, and welfare centers by requiring the City's Human Resource Administration to ensure language assistance services (including interpretation services and translated signs and documents) for Limited English Proficient individuals seeking to access benefits.

While these language access laws enabled many community members to receive needed language assistance in the health care setting, Asian Americans continue to face challenges communicating with health providers and receiving linguistically appropriate health information. Under Executive Order 120, *Citywide Policy on Language Access*, the top 6 languages other than English are required to be translated and provided interpretation at city agencies. Even for languages like Cantonese, Mandarin, and Korean which are among these top 6 languages, immigrants have still encountered barriers to receiving linguistically appropriate care.

> *"Many hospitals put up signs stating that they provide different translation services. But these are just signs. When I asked for help with translation, I found out that there are no such services in my language."*

> *"I have asked a family member or friend who speaks English to take a day off from their work to accompany me when I have to go to the hospital."*

> *"When I had to recertify my health insurance, I had to bring the recertification forms to either my social worker or pay someone else to fill them out because I cannot read English."*

Furthermore, hospitals rarely have mechanisms to translate and care for immigrant groups that are smaller in number and for languages that are less commonly spoken. Because of racial and/or cultural assumptions, many immigrants were asked to settle for a translator that spoke a more commonly spoken Asian language, even when they had little understanding of that language. Another major problem these participants faced was that translators were usually available only via telephone. Participants felt important medical information was lost or not properly communicated. Several participants seemed to have a limited understanding of what transpired during their hospital visits and questioned the diagnosis they received. Additionally, it was not uncommon to hear participants express concern about long waiting times for translation services – upwards of 3 to 4 hours.

> *"Nepali translators are rarely available at the hospital. I was asked if I understood Hindi because they could not find someone to interpret in Nepali. I only speak a little Hindi but what could I do?"*

> *"I don't like to use the telephone translation. I think the doctor did not diagnose my problem properly because I could only communicate a little information. I felt that I wasn't told everything I needed to know about my sickness. I was given medicine but I didn't know what type it was."*

Participants also spoke about their preference to be seen by a doctor who shared their ethnic heritage and spoke their language. Some participants go through great lengths in order to see a provider who understands their culture and with whom they are able to communicate. Others also mentioned the preference of going to a community provider rather than seeking services at large hospitals and other healthcare facilities.

"I think having a Filipino doctor is important for better health care access. We can understand each other better and I don't have a hard time communicating my problems."

"Some people I know travel 1.5 – 2 hours from their local community to get healthcare. This includes people from New Jersey coming to New York City for care. Locating language services near where people live is important. There should be local healthcare facilities where Vietnamese live that are able to provide them language services and patient navigation."

Few Health Education and Outreach Efforts are Targeting Asian Americans

When there are already significant economic and language barriers that come between Asian Americans and access to sufficient medical care, it becomes incredibly important to educate communities on how to navigate the complex health system. Our participants have articulated how their fervent desire to learn more about healthcare is deflected by the fact that there is no outlet for them to learn this information. Because there is little to no outreach and education targeting the Asian American community about their options for health insurance, resources available, and their rights as patients, it is difficult for our participants to understand the process, eligibility requirements, services, and choices. Many of our participants talked about how word-of-mouth was their primary method of learning about the complex system of public health insurance. That is not enough for something as important as their health.

"Educational workshops and lists would be helpful. I want a source for accurate and reliable information regarding doctors. Directories published by insurance companies are not reliable."

"I want to get more engaged in health reform but all the jargon gets in the way. I'm confused by (the) bills and what they include."

"Even if people have insurance they don't know their full rights and benefits under their own coverage. No one explained it to them."

"People are unaware of special patient assistance programs, CHCs (community health centers), sliding fee programs and HHC (Health and Hospitals Corporation) options, which would enable the uninsured to receive healthcare."

"I find the health care system so intimidating. When I get sick, I prefer to take a rest than go to the doctor."

IMPLICATIONS OF THE HEALTH CARE REFORM LEGISLATION

On March 30, 2010, President Barack Obama signed into law the *Health Care and Education Reconciliation Act of 2010 (H.R. 4872)*. The Reconciliation Act enhances provisions of the *Patient Protection and Affordability Act (H.R. 3590)* which was signed into law by President Obama on March 23, 2010. This historic health care reform legislation will increase access to care for approximately 32 million Americans. Starting in 2014, most U.S. citizens and legal residents will be required to have health insurance. As a new system is developed to make health care coverage accessible and affordable for millions of uninsured Americans, Project CHARGE looks at the following 8 key areas that we believe will impact the health of the Asian American community in New York City. (See Appendix C: *Implementation Timeline for Health Care Reform*).

1. Affordability

- Individual Credits & Subsidies - Affordability credits for premiums and cost-sharing will be available for U.S. citizens and legal immigrants who have incomes up to 400% of the federal poverty level. Childless adults are now eligible as well.
- Small Business Tax Credits - Affordability credits will be available immediately to help small businesses afford health coverage (less than 25 full-time employees and/or average wages less than $50,000/year). This includes a credit up to 35% of the employer's contribution to provide health

Table 3: Project CHARGE Priorities and Recommendations

Priorities	Provisions	Impact
1. Affordability	Credits & Subsidies for Individuals, Small Businesses and Self-Employed to Purchase Health Insurance Plans in the Exchanges	Positive *Recommendation: While generally positive, ensure that employers are not unfairly favoring one type of employee over another to avoid mandate.*
	Rebates & Discounts for Out-of-Pocket Prescription Costs	Positive *Recommendation: While generally positive, push for higher amount of rebate in 2010.*
2. Expansions in Coverage & Care	Dependent Coverage to Age 26	Positive
	No out-of-pocket costs for certain types of preventive care	Positive
3. Immigrant Inclusion	5-Year Waiting Period for Legal Immigrants	Negative *Recommendation: Provide States the option to restore Medicaid eligibility of legal immigrants within their first 5 years of residence.*
	Undocumented Immigrants & Exchange	Negative *Recommendation: Allow undocumented immigrants to purchase health coverage at full costs with their own money.*
	Additional Verification to Access Exchange	Negative *Recommendation: Keep the current verification used by States to determine eligibility for coverage options.*
4. Language Access & Cultural Competency	Language Requirements for All Insurance Summaries, Claims, and Notices	Positive
	Lack of Standards for Language Access	Negative *Recommendation: Establish Culturally and Linguistically Appropriate Services (CLAS) standards for insurers in the Exchange.* *Recommendation: Federal funds should be allocated to states to establish a grant program to develop an infrastructure for language services.*
	No Enhanced Matching Rate for Reimbursement of Language Services	Negative *Recommendation: Extend the enhanced federal matching rate for language services to Medicaid providers that offer these services to their adult patients.*
	Cultural Competency Provisions	Positive
5. Consumer Protection, Accountability, and Outreach	Consumer Protections from Discriminatory Insurance Practices	Positive
	Accountability Requirements for Insurer	Positive
	Consumer Assistance Resources	Positive
6. Disparities	Improved Data Collection & Reporting	Positive
	Workforce Development	Positive
7. Safety Net	Increased Funding for Community Health Centers	Positive
	Protections for Safety Net Unclear	Negative *Recommendation: Ensure funding for safety net hospitals and providers are in tact as they will continue to serve low-income individuals that don't qualify for affordability credits or get coverage through employers.*
8. State Commitments	Expand Medicaid to 133% FPL and to childless adults	Positive
	State Relief and Support is Less for States with More Generous Public Programs	Negative *Recommendation: Ensure access and do not retrench from the promise of covering uninsured during tough economic times.*

insurance for employees. For small nonprofit organizations, the credit is 25% of employer's contributions.


Self-Employed Business Owners - Affordability credits will be available on a sliding scale basis for premiums and there will be caps on out-of-pocket costs for self-employed business owners.


Out-of-Pocket Prescription Costs - $250 rebates will be provided for Medicare Part D enrollees who enter the "donut hole" to help pay for prescription drugs. In subsequent years, additional discounts will be provided for seniors. The coverage gap will continually narrow until it disappears by 2020.

Making certain there are truly meaningful, affordable choices for individuals and small businesses to get the coverage they need is key to health reform. Affordability is paramount in determining whether an individual will seek care when he/she needs it or delay care due to other competing economic priorities. Small businesses also face the challenge of coverage for their employees in a market that has seen double digit increases in premiums yearly.

Subsidies/tax credits the health care reform legislation will make insurance more affordable to thousands of citizens and lawfully residing immigrants who currently make too much money to qualify for public programs like Medicaid, are not offered insurance through their employer, or currently cannot afford to buy insurance on their own. However, the current legislation does not extend this to all lawfully present individuals such as all non-immigrant visa holders who reside in the U.S. (See Appendix B: *Requirements and Subsidies Under Health Care Reform*).

Additionally, affordability credits will be available immediately to help small businesses afford health coverage (less than 25 full-time employees and/or average wages less than $50,000/year). This includes a credit up to 35% of the employer's contribution to provide health insurance for employees. For small nonprofit organizations, the credit is 25% of employer's contributions. **Affordability credits for Asian American-owned small businesses and self-employed individuals are important as Asian Americans are among the most likely to own their own business** (U.S. Census Bureau, 2000). Among foreign-born Asian Americans, Koreans have the highest rate of self-employment at 28% (U.S Census Bureau, 2000). In 2002, there were 1.1 million Asian American-owned businesses, generating more than $326 billion in revenues (up 8 percent from 1997), and employing 2.2 million people (U.S. Census Bureau, 2006).

Under the new health care reform legislation, employers are penalized for not providing health coverage if they have at least one worker receiving affordability credits as a result. This method may incentivize employers not to hire low-income but qualified individuals in favor of higher income individuals or to hire married individuals versus single parents. *A critical improvement would be to change this penalty system to ensure that employers don't unfairly favor one type of employee over another.*

$250 rebates will be provided for Medicare Part D enrollees who enter the "donut hole" to help pay for prescription drugs. In subsequent years, additional discounts will be provided for seniors. The coverage gap will continually narrow until it disappears by 2020. **These rebates and discounts are especially beneficial for elderly from communities of color, like Asian American seniors.** These elderly have disproportionately higher rates of disease and are more likely to live in poverty compared to non-Hispanic white elderly. *While this is a great step to providing affordability for seniors, a critical improvement would be to increase the amount of the rebate provided in 2010 for Medicare Part D to help further defray the costs of their medications.*

2. Expansions in Coverage and Care


Dependent Coverage - Starting in 2010, unmarried adult children can remain on their parents' insurance plan up to age 26.


Preventive Care - Under new plans, consumers will not have to pay out-of-pocket costs for wellness and preventive care.

It estimated that 45% of all young adults between the ages of 19 to 29 years went without health coverage at some point in 2009 (Nicholson and Collins, 2009). **A significant change resulting from the health care reform legislation is that insurers will be required to allow all unmarried adult children to remain on their parents' health insurance until age 26.** This has significant

implications for Asian American young adults. About 40% of all Asian Americans are under the age of 30 years in 2008 (U.S. Census Bureau, 2009). There are approximately 2.2 million Asian American young adults between the ages of 20 – 29.

Young adults in their late teens and early twenties face numerous life transitions that many times leave them without health coverage. Some job-based insurance requires that young people must be in school full-time in order to stay on their parents' coverage. Other policies limit eligibility coverage to age 21 or 23. Given the current economic downturn, many young people are finding it increasingly harder to find employment that offers health insurance. Moreover, many chronic conditions often develop during this time in a young person's life. Early diagnosis and treatment are essential to making sure young people can continue to productive and contribute to the society at large.

Free preventive care under new private plans will now be required under the health care reform legislation. There will be no co-payments and cost-sharing for certain screenings such as mammograms, immunizations, and screenings for cancer, cardiovascular disease, and diabetes as well as preventive care for babies, children, and adolescents. Facilitating access to preventive services is of utmost importance as expenditures for health care in the United States continue to rise and topping at over $2.5 trillion in 2009 according to the Centers for Medicare and Medicaid Services (Truffer, C.J. et al., 2010). Much of these costs can be attributed to the diagnosis and treatment of chronic diseases and conditions such as diabetes, obesity, cardiovascular disease and asthma. Unfortunately, a much smaller amount is spent on stopping the development of these conditions – many of which are preventable.

Access to preventive services is vital to improving Asian American health. According to data released in a special issue by the American Journal of Public Health (AJPH) in 2010, studies reveal that distinct groups of Asian Americans, Native Hawaiians, and Pacific Islanders (AA and NHPI) differ widely in death and disease rates. Various Asian American populations suffer disproportionately from a range of cancers. Culturally and linguistically appropriate prevention measures would have a major impact in reducing rates of breast, lung, colorectal, cervical, and liver cancer among different Asian American groups. In addition, chronic conditions like hypertension, high cholesterol, diabetes, and obesity are increasing among Asian Americans as they adapt and acculturate to life in the United States. They stand to benefit greatly from accessing culturally appropriate preventive care.

These provisions are important positive changes in ensuring optimal health throughout the lifespan for individuals and families. Investments in expanding coverage for young people and providing preventive care to everyone will help contain costs in years to come.

3. Immigrant Inclusion

- 5-Year Waiting Period for Legal Immigrants - Legal immigrants who would otherwise qualify for these services are unfairly denied access to public programs for five years.
- Undocumented Immigrants & the Exchange - Undocumented are prohibited from using their own money to purchase insurance through the Exchange at full cost.
- Additional Verification - To prevent undocumented immigrants from accessing the Exchange, the health care reform legislation includes additional, burdensome citizenship verification requirements. States already implement a verification system to determine eligibility for public programs and this would create more administrative burdens.

We believe in the overall goal of health care reform to expand the number of individuals who have access to quality, affordable health insurance and to reduce the number of uninsured in America. In order to do so, health care reform must be truly inclusive and accessible where no one is left out. However, this is not a reality for many individuals and families. Currently, many of the most vulnerable segments of our community are shut of participating in our healthcare system.

The 5-year waiting period for legal immigrants was not eliminated. Legal immigrants who would otherwise qualify for Medicaid are unfairly denied access to the program for five years even though they pay taxes like everyone else and help subsidize all public programs. With the mandates included in the health care reform legislation, these same individuals will now be required to purchase insurance unless they can prove financial hardship.

However, in New York, public programs like Medicaid and Family Health Plus is extended to all lawfully residing immigrants who meet income eligibility regardless of their time in the U.S. This is provided with state-only money. States, like New York, should not be penalized if they choose to continue to provide coverage to their residents beyond the parameters of the health care reform legislation. In the days before the Senate vote of their version of the bill in December 2009, Senator Menendez introduced an amendment 2991 (co-sponsors included New York Senators Schumer and Gillibrand) giving states the option to restore Medicaid to legal immigrants within their first five years of residence. Unfortunately, the amendment did not come to a vote before the Senate bill was passed. Given the economic downturn, progressive states may face future recession of this benefit. Allowing these states to restore eligibility would provide them welcome fiscal relief.

Letting immigrants pay into the health care system will save money over time and will help bring down costs for everyone. In addition, coverage will also facilitate their access to timely preventive care as opposed to waiting until their conditions are far worse. **Unfortunately, the health care reform legislation prohibits undocumented immigrants from using their own money to purchase health coverage at full costs in the Exchanges.** This is counterproductive to the goal of health care reform to expand health care access and reduce the number of uninsured. This leaves undocumented immigrants few options for affordable health care.

To prevent undocumented immigrants from accessing the Exchange, the health care reform legislation includes additional, burdensome verification requirements. States already implement a verification system to determine eligibility for public programs and this would create more administrative burdens. **Past attempts to implement these kinds of additional verification measures have actually prevented U.S. citizens and legal immigrants from receiving the health care they need.** According to a 2007 GAO study, verification requirements cost significantly more to implement than they have saved in expenditures by excluding unauthorized immigrants from Medicaid coverage. Among the six states surveyed, costs to taxpayers to implement the verification procedures totaled $16.6 million—which only yielded 8 unauthorized immigrants. The study also found that the verification requirements resulted in U.S. citizens and legal immigrants being delayed or denied Medicaid because they could not provide the necessary documentation (GAO, 2007).

While the health care reform legislation is a tremendous first step, we recognize that in its current form it will still leave thousands out, such as undocumented immigrants who are being prevented from participating in this new system. Hopefully, such overhaul and improvements will come in the very near future and all residents in U.S. will reap the promise of universal health care.

4. Language Access and Cultural Competency

Language Requirements - All insurance summaries, claims, and notices to enrollees must be provided in culturally competent and linguistically accessible (CCLA) manner.

Standards for Language Access - Despite the CCLA requirements, the health care reform legislation does not include standards in which this will be done across health plans.

Matching Rate - An enhanced matching rate for the reimbursement of language services was not included in the health care reform legislation.

Cultural Competency - There are several provisions that focus specifically on culturally competent care in the areas of pediatric health care workforce expansion, primary care training and enhancement, education and training in pain care, and mental and behavioral health education and training grants.

Because over 26% of Asian Americans in New York City are Limited English Proficient, ensuring language access is critical to improving their health and well-being. **The health care reform legislation does include several cultural competency and language access provisions.** All insurance summaries, claims, and notices to enrollees must be provided in culturally competent and linguistically accessible (CCLA) manner. Additionally, cultural competency will be enhanced in the areas of pediatric health care workforce expansion, primary care training and enhancement, education and training in pain care, and mental and behavioral health education and training grants.

Despite the CCLA requirements, the health care reform legislation does not include standards in which this will be done across health plans. *A critical improvement to this current provision will be to establish Culturally and Linguistically Appropriate Services (CLAS) standards for insurers in the Exchange. Additionally, federal funds should be allocated to states to develop an infrastructure for language services.*

This funding can support state certification of health interpreters and bilingual health professionals, workforce development initiatives, implementation of technological innovations such as video interpreting and telemedicine, development of centralized language services including translation of applications, forms and patient information, and support for local and regional language banks. Investments in language services now will reduce the costs for all of us in years to come. Once the infrastructure is built, it could potentially be maintained through reimbursement mechanisms provided by various federal and state programs.

Additionally, an enhanced matching rate for the reimbursement of language services was *not included* in the health care reform legislation. *A critical improvement to the current legislation will be the inclusion of a provision that extends the federal matching rate for language services*. For instance, a 75% matching rate is available for providers that offer language services for children in Medicaid and the Children's Health Insurance Program. This should be extended to Medicaid providers that offer language services to their adult patients.

5. Consumer Protection, Accountability, and Outreach

- Consumer Protections - There are several provisions that protect health consumers from discriminatory insurance practices. These include prohibiting denials of coverage based on a pre-existing conditions for adults and children. It also guarantees access to coverage regardless of age, gender, or health status. Additionally, the legislation eliminates lifetime and annual coverage limits.

- Accountability - Health insurance companies will be held accountable for how premium dollars are spent. They will now be required to spend 80-85% of their premium dollars on patient care. If insurers fail to do this, they will be required to provide refunds to their consumers.

- Consumer Assistance Resources - All insurers in the Exchanges will be required to present health information in a clear, user-friendly format that allows consumers to understand and compare available benefits and plans. Insurers will be subject to marketing requirements and uniform standards for information dissemination. Consumers will have a variety of ways to apply for subsidy programs through a single form.

There are a number of provisions that provide consumer protections to ensure that individuals and families can keep coverage when they need it the most. The health care reform legislation will eliminate discriminatory insurance practices. These include prohibiting denials of coverage based on a pre-existing condition for adults and children. It also guarantees access to coverage regardless of age, gender, or health status. Additionally, the legislation eliminates lifetime and annual coverage limits. This will provide individuals and families as sense of security and aid in containing their medical costs.

The health care reform legislation will hold insurance companies accountable for how premium dollars are spent. They will now be required to spend 80-85% of their premium dollars on patient care and not for profits, advertising, and other overhead costs. Patient care is any service performed by a health professional or non-health professional for the benefit of the patient. These can include treatments, counseling, patient education, and administration of medication. If insurers fail to do this, they will be required to provide refunds to their consumers.

Comprehensive health care reform must also address issues beyond coverage and costs. Simply having health insurance is not enough. While obtaining insurance is a first step, many communities are frustrated and confused by how to navigate our complex health care system. **Health education and outreach initiatives as well as consumer assistance programs are critical in helping community members learn their rights as patients and linking them with necessary resources and services.**

Simplification of enrollment and the creation of a centralized repository of health plans is an integral building block for health reform. The health care reform legislation requires resources such as a consumer assistance hotline, a customer service call center, a website, and contracted navigators to conduct outreach and enrollment assistance. Additionally, the legislation requires states to develop a single form for applying and renewing for a state subsidy program and it can be done by filing online, in person, by mail, or by phone. Insurers will also be subject to marketing requirements and uniform standards for information dissemination. These are all great steps to facilitating and streamlining access to the thousands of individuals, families, and businesses seeking to sign up and manage their health coverage. *A critical improvement to this provision is to ensure that mechanisms will be in place for Limited English Proficient individuals to use these resources*.

6. Disparities

Data Collection - Within two years, any federally conducted or funded research, public health programs, or activity must collect and report data on race, ethnicity, sex, primary language, and disability status. Additionally, efforts to oversample populations that have traditionally had low participation in research studies will be implemented as well as ongoing monitoring to determine trends in health disparities.

Workforce Development - Several provisions were included in the health care reform legislation that will improve workforce training and development, provide scholarships and loan repayment programs, training in cultural competency, as well as funding for community health workers.

Communities of color disproportionately face health challenges compared to the overall population stemming from higher rates of certain diseases as well as a lack of access to culturally competent and linguistically appropriate care (Palmer, 2009). Establishing baseline data and developing a monitoring system is critical to understanding the scope of disease burden in communities. Data also plays a role in helping federal, state, and local governments as well as public health systems to determine priority areas for wellness, prevention, and treatment programs.

Unfortunately, data on Asian American health is scarce and not reported due to small sample sizes. Additionally, many studies do not disaggregate data collected by subgroup and masks the distinct differences of health issues facing the over 40 ethnic groups comprising the Asian American community. This lack of data has created an incomplete picture of the health of our community. **The health care reform legislation contains provisions to improve the collection of data on race, ethnicity, primary language, geographic area, and disability. Requirements to oversample populations that have traditionally had low participation in research studies as well as ongoing monitoring to determine trends in health disparities are also included.**

Several provisions were included in the health care reform legislation that will improve workforce training and development. Numerous reports indicate the health system is experiencing or will soon experience a shortage of health professionals. Many people of color and low-income people live in medically underserved areas, where the shortages already exist. The top 5 medical underserved counties in the United States with an Asian American and Pacific Islander population of 100,000 or more included: San Francisco County, CA, Kings County, NY, Alameda County, CA, New York County, NY, and Queens County, NY (Chang Weir R., Tran L., and Tseng W., 2005). These communities stand to benefit greatly with an increase in the number of cultural competent and linguistically responsive providers serving in their area.

There is a special emphasis on increasing the number of doctors, nurses, and public health professionals, particularly primary care providers and those that work in rural and other medically underserved areas in the health care reform legislation. This incorporates Centers for Disease Control and Prevention funding of grant awards from 2011-2016 to promote the use of community health workers in communities that are medically underserved. Other provisions to address workforce shortages also include scholarships, grants, and loan repayment programs, promoting training of a diverse workforce as well as cultural competency training of health professionals.

7. Safety Net


Community Health Center - Funds will be increased by $11 billion over 5 years towards community health centers to expand and build their capacity to serve thousands of newly insured patients.


Safety-Net Hospitals and Clinics - While the health care reform legislation will expand coverage to nearly 32 million individuals, there will be many that remain uninsured. The funding of safety net providers must continue to be protected as they will continue to offer affordable care for many low-income individuals and families that do not qualify for affordability credits or get coverage through their employers.

For decades, community health centers have played a critical role in providing affordable quality primary healthcare, dental care, mental health services, and low-cost prescription drugs to low-income and medically underserved communities. According to the Association of Asian Pacific Community Health Organizations, more than 300,000 patients receive care at 25 Asian and Pacific Islander-serving community health centers. Over 80% of these patients are uninsured or underinsured. It is imperative that facilities like community health centers receive increase support to build their capacity to serve the future pool of newly insured patients. **The $11 billion in new, dedicated funding for the community health centers will ensure and strengthen their ability to provide care for over 20 million new individuals.**

While health care reform will expand and require coverage to the more than 47 million people without insurance, many will still remain uninsured. It is estimated that 96% of U.S. residents under 65 years will be insured under health reform. There will still be between 18 – 24 million that will remain uninsured, with close to one-third being undocumented immigrants. There will also be individuals that do not qualify for affordability credits or will be employed in certain small businesses that are exempt from the mandate. **Policymakers are urged to protect funding of safety net providers as they will continue to offer affordable care for many low-income individuals and families that do not qualify for affordability credits or get coverage through their employers.**

8. State Commitment


Medicaid - The new health care reform legislation expands Medicaid to 133% of the federal poverty level. All newly eligible adults (non-elderly, non-pregnant) will be guaranteed a benchmark benefit package that at least provides the essential health benefits.


State Relief and Support - To finance coverage for newly eligible Medicaid recipients, states will receive 100% of federal medical assistance percentage (FMAP) funding in 2014. This will draw down to 90% by 2020. For states that already provide expansion of eligibility to adults with incomes up to 100% of the federal poverty level (like New York), they will receive a phased-in increase in funding for FMAP so that by 2019 all states will receive the same federal financing for Medicaid.

According to the New York City Department of Health and Mental Hygiene Community Health Survey (2008), the Asian American community like many communities throughout the state experienced a significant decline in the number of uninsured. The number of uninsured Asian Americans decreased from 19% in 2007 to 12% in 2008 (NYC DOHMH, 2010). These tremendous strides cannot be underscored and New York State serves as an example for its commitment to cover more and more individuals and families despite the current economic crisis.

The reasons for the decline may be due to the state's expansion of Medicaid and health insurance eligibility, as well as improvements in the enrollment process. For example, children and pregnant women are eligible for Medicaid and/or Child Health Plus in New York State without regard to immigration status. New York State has expanded eligibility for Child Health Plus and Family Health Plus to 400% and 200% of the federal poverty level respectively. The state has also initiated presumptive eligibility for children in Medicaid, eliminated asset test and reduced documentation requirements for Medicaid and Family Health Plus and eliminated face-to-face interviews. **Under the health care reform legislation, Medicaid will be expanded to 133% of the federal poverty level. All newly eligible adults (non-elderly, non-pregnant) will be guaranteed a benchmark benefit package that at least provides the essential health benefits.**

However, the risk from the current state of the health care reform legislation is that states like New York who support more generous programs will receive less federal assistance to cover the newly insured. To finance coverage for newly eligible Medicaid recipients, states will receive 100% of federal medical assistance percentage (FMAP) funding in 2014. This draws down to 90% by 2020. For states that already provide expansion of eligibility to adults with incomes up to 100% (like New York), they will receive a phased-in increase in funding for FMAP so that by 2019 all states will receive the same federal financing for Medicaid. Given tough economic times, more generous states face difficult decisions about what it can afford to provide its residents moving forward. **We strongly urge policymakers from states that offer more generous health programs and initiatives to continue the commitment to ensuring access to its residents and not to retrench from the promise of covering the uninsured.**

CLOSING

What the community health discussions showed Project CHARGE was that Asian Americans are eager to share their stories, concerns, and suggestions to improve our healthcare system. 42% of participants indicated that they want to learn more information about health care reform. 21% also wanted more opportunities to discuss health care reform and how it will impact themselves and their families. When asked what the best way is to inform policy makers on how to develop a plan to address health system problems, 73% of participants believed that community meetings are the best forum to do so.

As the next phase of health care reform now turns to states to develop their implementation plans, finding ways to involve community members is crucial to shaping sound processes for education, outreach, coordination, execution, and evaluation of this new health care system. Policymakers must prioritize engaging all communities, including Limited English Proficient, newly arrived immigrants, and low-income communities. The costs of not doing so are enormous, and all of us will lose out in building a healthy, productive country together.

Appendix A: PARTICIPANT DEMOGRAPHICS (N=128)

GROUP DISCUSSIONS

Project CHARGE conducted 15 community discussions and 11 one-on-one interviews with a total of 128 participants.

Group sizes ranged from 5-16 participants for the community discussions. The collaborative decided to do one-on-one interviews due to the nature of the services provided by some of our partners and to be sensitive to the confidentiality issues of clients they serve. Many of the community discussions and interviews were conducted in the native languages of the participants.

Participants were asked questions related to the following areas:

- Their current situation such as what they do when they are sick and where they go.
- Their insurance status and what factors did they consider when choosing a health plan if they were insured.
- The cost of care and what issues they may have encountered paying for care.
- Suggestions for better access such as what would make it easier for them to get care.
- What they believe is most important: choice, quality, or reducing costs.

SURVEYS

Before each community discussion or one-on-one interview, each participant was asked to fill out a survey to collect demographic information and to get a sense of his or her health priorities and concerns. The survey also asked for suggestions for the best way policymakers can develop a plan to address the health system problems and how participants can engage in the health care reform debate. These surveys were available in English and several Asian languages.

Participant Demographic Information (N=128)

Measure	Breakdown	Percentage	Total
Gender	Female Male	78% 22%	(100) (28)
Age Range	18-86		
Average Age	43		
Immigration History	Foreign born US born Unanswered	83% 14% 2%	(107) (18) (3)
Ethnicity* **some participants represented more than one ethnicity.*	Asian Indian Bangladeshi Chinese Filipino Japanese Korean Nepalese Pakistani Vietnamese	2% 14% 31% 13% 16% 11% 6% 1% 8%	(3) (18) (40) (16) (20) (14) (8) (1) (10)
Occupation	Employed Unemployed Student Housewife Retired Unanswered	42% 14% 13% 13% 7% 10%	(54) (18) (17) (17) (9) (13)
Length of Residence in U.S.* **The average length of residence in the United States for immigrant survey respondents was 14 years with the range being from less than 1 year to 60 years.*	Less than 5 years Between 6-10 years 11 or more years Unanswered	31% 21% 42% 7%	(32) (22) (45) (7)
Income* **Results should be interpreted with caution. Survey question did not specify personal versus household income.*	Less than $10,000 $10,000 - $25,000 $25,001 - $45,000 $45,001 - $75,000 $75,001 - $100,000 Greater than $100,000 Unanswered	42% 16% 13% 15% 1% 2% 11%	(54) (21) (16) (19) (1) (2) (15)
Insurance Coverage	Private/Employer Public Uninsured Unanswered	24% 52% 21% 2%	(31) (67) (27) (3)
Children's Insurance Coverage **Adults were asked what type of coverage their children have*	Private/Employer Public Uninsured	22% 75% 3%	(8) (27) (1)
Doctor Visit in Last 12 Months	Yes No	87% 13%	(111) (17)
Reasons for Doctor Visit in Last 12 Months* **Some respondents chose more than one answer.*	Routine Check-Up Emergency Child or Family Member Other	70% 24% 13% 20%	(66) (21) (11) (17)

APPENDIX B: REQUIREMENTS AND SUBSIDIES UNDER HEALTH CARE REFORM

Who Is Required to Have Insurance?

Individual	
Required • U.S citizens • Legal immigrants Penalties • $95 in 2014 • $325 in 2015 • $695 or higher in 2016 • Penalty based on cost of living adjustment after 2016	Exempt • Financial hardships • Religious objections • American Indians • Without coverage for less than 3 months • Undocumented immigrants • Those for whom the lowest plan option exceeds 8% of individual's Income • Those with incomes below tax filing threshold
Employer	
Required • Businesses with more than 50 employees • Businesses that offer coverage to their employees will provide a voucher equal to the amount of money it contributes to a health policy. The employee can use the voucher to purchase insurance through the Exchange. Only applicable for employees with incomes less than 400% FPL or whose premiums is between 8 – 9.8% of premiums. Penalties will not be assessed to employer providing vouchers. • Businesses with more than 200 employees must automatically enroll employees to health insurance plans. Employees can opt out of coverage. Penalties • $2000 per worker each year if any worker receives federal subsidies to purchase health insurance. Fines applied to entire number of employees minus some allowances.	Exempt • Less than 50 employees exempt from penalties

Source: Henry J. Kaiser Family Foundation. Focus on Health Reform: Side-By-Side Comparison of Major Health Reform Proposals. March 24, 2010.

Who Will Get Subsidized?

Individual & Families		
Income Level	**Amount of Credit**	**Coverage Options in NYS**
Less than 133% FPL *Single: $10,830* *Family of 4: $22,050*	Premium Credit* 2% of income	Medicaid Family Health Plus (Single) Exchange* Employer
Up to 400% FPL *Single: $43,320* *Family of 4: $88,200*	Sliding Scale Premium Credit* 133 - 150% FPL: 3 - 4 % of income 150 - 200% FPL: 4 - 6.3% of income 200 - 250% FPL: 6.3% - 8.05% of income 250 - 300% FPL: 8.05 - 9.5% of income 300 - 400% FPL: 9.5% of income Sliding Scale Cost-Sharing Credits* 100 - 150% FPL: 94% 150 - 200% FPL: 85% 200 - 250% FPL: 73% 250 - 400% FPL: 70%	Family Health Plus (Family:150% FPL) Exchange* Employer
Over 400% FPL	No credits	Exchange Employer
Employer		
25 or less employees; and/or average wages of $50,000	Sliding Scale Tax Credit* up to 35% in 2010 - 2013 up to 50% in 2014 *10 or less employees and/or average wages less than $25,000 get maximum amount of credits*	Small Business Health Options Programs ("SHOP Exchange")
Nonprofit organizations	25% in 2010-2013 35% in 2014	Small Business Health Options Programs ("SHOP Exchange")

Notes:

**Affordability credits are only offered to purchase insurance through the Exchanges.*

- *Premium: The amount an individual or an employer pays to the health plan each month to purchase health coverage.*
- *Cost-sharing: The share of health expenses that a consumer must pay, including the deductibles, co-payments, co-insurance, and charges over the amount reimbursed by the medical plan.*

Source: Small Business Majority, 2010. http://smallbusinessmajority.org/hc-reform-faq/index.php#2a
Main Street Alliance, 2010. http://mainstreetalliance.org/wordpress/

APPENDIX C: IMPLEMENTATION TIMELINE FOR HEALTH CARE REFORM

On March 30, 2010, President Barack Obama signed into law the Health Care and Education Reconciliation Act of 2010 (H.R. 4872). The Reconciliation Act enhances provisions of the Patient Protection and Affordability Act (H.R. 3590) which was signed into law by President Obama on March 23, 2010. This historic health care reform legislation will increase access to care for approximately 32 million Americans. Health care reform will be financed through a variety of mechanisms such as new taxes, mandates, and cost savings measures. Below is a timeline of when particular provisions mentioned in this report and financing mechanisms will take effect.

2010

Affordability

- *Small business tax credit*
- *Rebates of $250 for Part D "donut hole"*

Expansions in Coverage and Care

- *Extending dependent coverage for unmarried children up to age 26*
- *Covering preventive health services in new health plans and individual market*
- *Creating Interagency Council on Health Promotion Policy*
- *Establishes a Prevention and Public Health Investment Fund*

Consumer Protections, Accountability, and Outreach

- *Immediate access to insurance for uninsured adults with pre-existing conditions*
- *Eliminates pre-existing conditions exclusions for children.*
- *Prohibiting recissions on existing health insurance policies when a person gets sick*
- *Eliminates lifetime limits and restrictive use of annual limits.*
- *Accountability for unreasonable rate hikes by insurance companies*
- *Aid for States to establish an Office of Health Insurance Consumer Assistance*
- *Development of State websites for residents to identify coverage options*

Disparities

- *Tax Relief for health professionals with state loan repayment*
- *Establishing a National Health Care Workforce Commission*
- *Expanding and improving low-interest student loan programs, scholarships and loan repayments for health students and health professionals.*

State Commitment

- *Medicaid flexibility to states to cover parents and childless adult up to 133% FPL.*

Financing

- *States receive 50% - 100% Federal Medical Assistance Percentage (FMAP) dollars for Medicaid expansions.*
- *Imposing a 10% Indoor Tanning Services Tax*
- *Cost Savings through enhanced screening procedures for health providers to eliminate waste and fraud*

2011

Affordability

- *50% discounts for brand-name drugs and phasing in of additional discounts for both brand-name and generic drugs in the Part D "donut hole"*

Consumer Protections, Accountability, and Outreach

- *Annual reporting requirements by health insurers on share of premiums spent on medical care. Rebates given to consumers if insurer is not compliant with 80-85% spending requirements.*

Expansions in Coverage and Care

- *Covering free, annual wellness visits and personalized prevention services for Medicare beneficiaries*
- *Requiring new plans to cover preventive services with little to no cost sharing*
- *Creating incentives for State Medicaid programs to cover preventive services with no cost sharing*
- *Requiring coverage of tobacco cessation services for pregnant women*

Disparities

- *Redistributing unused training slots to increase primary care training at other sites*
- *Expanding funding for scholarships and loan repayments for primary care providers in underserved areas*
- *Expanding training opportunities for primary care, nursing, and public health workforce*

Safety Net

- *Providing funds to build new and expand existing community health centers*

Financing

- *Increased additional tax for withdrawals from health savings accounts and Archer Medical Savings Account Funds for non-qualified medical expenses.*
- *Imposing an annual, non-deductible fee on pharmaceutical manufacturing companies*

2012

Financing

- *Cost savings by implementing physician payment reforms that enhance payment for primary care services*
- *Cost savings by linking payment to quality outcomes for acute care hospitals*
- *Cost savings by establishing financial incentives to encourage hospitals to reduce preventable readmissions*

2013

Consumer Protections, Accountability, and Outreach

- *Administrative simplification through uniform standards and business rules for electronic exchange of information*

Financing

- *Additional hospital insurance tax for high wage workers earning over $200,000 for an individual or $250,000 for married filing jointly*
- *Establishing a 2.3% excise tax on the sale of medical devices by a manufacturer or importer*
- *Annual fee for patient-centered outcomes research on insured and self-insured plans*

2014
Affordability
• *Individual and family tax credits for those between 133% to 400% FPL* • *2nd phase of small business tax credit* • *Penalties begin for non-exempt individuals, families, and employers that fail to obtain acceptable health coverage*
Expansions in Coverage and Care
• *Establishing Health Insurance Exchanges*
Consumer Protections, Accountability, and Outreach
• *Ends discriminatory practices to exclude coverage for treatment of pre-existing conditions and charge higher rates due to health status, gender, or other factors (except for age, geography, family size and tobacco use)* • *Eliminates annual limits for all employer plans and new plans in individual market*
State Commitment
• *Medicaid increases for all states up to 133% FPL for all non-elderly individuals.*
Financing
• *States receive federal funding for Medicaid expansions* • *Imposing an annual, non-deductible fee for health insurance providers*
2018
Financing
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